Gender & Tropical Diseases

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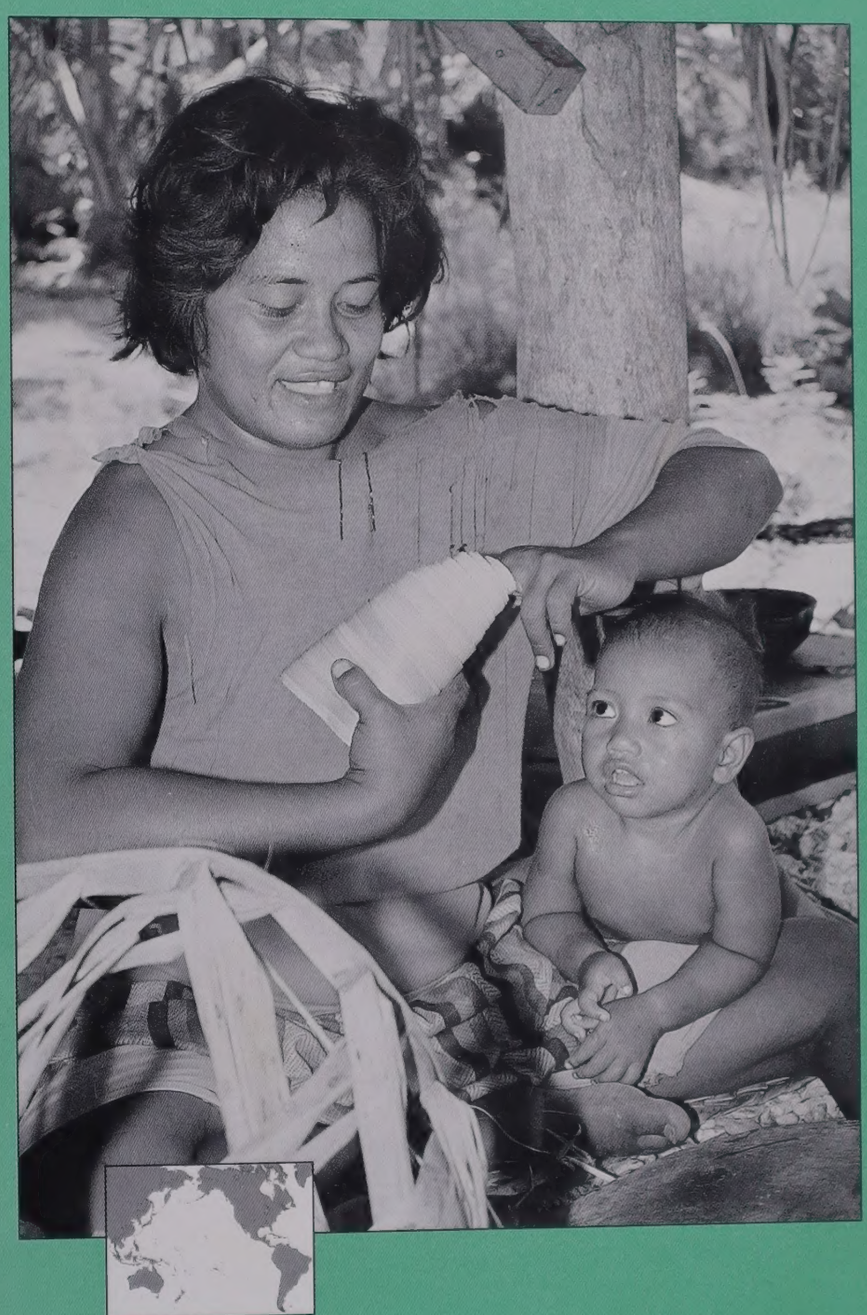

Women's participation in health and development projects

Lenore Manderson, Tanya Mark and Nicole Woelz

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ABSTRACT

This paper discusses women's health projects funded by Australian sources, with particular attention to those undertaken by non-governmental organizations (NGOs). These organizations have worked in various countries, in collaboration with community-based organizations, to identify priorities and to develop, implement and evaluate women's health projects. The paper is based on a review of unpublished reports and documents provided by the organizations involved, and on interviews with representatives from Australian NGOs. It focuses on strategies that have succeeded in increasing women's access to health services in developing countries, and highlights positive aspects for enhancing women's empowerment and decision-making power. The inclusion of community members - women, men and community leaders - at all stages of project implementation was key to their success and sustainability. Projects that were flexible and open to modification, according to changing needs and circumstances of their beneficiaries, were also more successful. The authors note that while many development projects targeted at women are under way, few of them are evaluated and documented for public reference. An important contribution of this paper is that it synthesizes and compares several important experiences, for use by others concerned with women's health interventions.

The **Gender and Tropical Diseases Resource Papers** appear as part of a series of unedited final reports resulting from projects supported by the UNDP/World Bank/ WHO Special Programme for Research and Training in Tropical Diseases (TDR). These reports are submitted to the TDR Task Force on Gender and Tropical Diseases for review and evaluation upon completion of a project. Project reports included in this series have not been published in their entirety elsewhere.

The designations employed and the presentation of the material in **Gender and Tropical Diseases Resource Papers** do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

Authors alone are responsible for the views expressed in the **Gender and Tropical Diseases Resource Papers** and for the presentation of the material contained therein.

Foreword

The UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) is a globally coordinated effort to bring the resources of modern science to bear on the control of major tropical diseases. The Programme has two interdependent objectives:

- To develop new methods of preventing, diagnosing and treating selected tropical diseases, methods that would be applicable, acceptable and affordable by developing countries, require minimal skills or supervision and be readily integrated into the health services of these countries:

- To strengthen - through training in biomedical and social sciences and through support to institutions - the capability of developing countries to undertake the research required to develop these new disease control technologies.

Research is conducted on a global basis by multidisciplinary teams of researchers on the six diseases selected for special attention: malaria, schistosomiasis, filariasis (including onchocerciasis), the trypanosomiases (both African sleeping sickness and the American form, Chagas disease), the leishmaniases and leprosy, and "trans-diseases" areas, including Applied Field Research. The Gender and Tropical Diseases Task Force is one of the initiatives of the Applied Field Research Steering Committee.

The Gender and Tropical Diseases Resource Papers series represents a new communication venture undertaken by TDR's Gender and Tropical Diseases Task Force. This series has been launched to facilitate and increase communication among social and health scientists, and others interested in gender issues in health, and to disseminate findings from TDR studies to disease control personnel and government officials concerned with improving the effectiveness of tropical disease control.

Resource papers published in this series are final reports of projects funded by TDR and usually include more material than ordinarily published in peer review journal articles. TDR considers this material to be valuable, especially for researchers and disease control personnel in tropical disease endemic countries who require more complete information on a topic than is generally provided in shorter journal articles.

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Preface

The Gender and Tropical Diseases Task Force was established in 1994 in order to develop and implement measures to improve the health of women in countries where tropical diseases are endemic. As part of the preparation for the Task Force, research for the present paper was undertaken with the support of the Australian International Development Assistance Bureau (AIDAB), now known as AusAID. It is therefore appropriate that this paper is the first of the new Gender and Tropical Diseases Resource Paper series.

This paper reviews Australian projects concerned with women's health, with special attention to those undertaken by non-governmental organizations (NGOs). It draws upon information from interviews with representatives of Australian NGOs, as well as a review of unpublished reports and documentation provided by these organizations.
While the projects all focus on aspects of women's health, an important underlying goal is the empowerment of women with a participatory approach involving women in the determination of needs and priorities to be addressed. This has become a central approach in the activities supported by the Gender and Tropical Diseases Task Force.

Gender inequities were addressed in nearly all case studies presented in this paper in recognition of the fact that women's participation in decision-making and their control over resources is key to sustaining the health benefits realized. The importance of gaining the support of men for women-centred interventions is also pointed out, especially with reference to one project where men felt slighted by their exclusion from project activities.

TDR has had a long and consistently positive relationship with the Tropical Health Program, Australian Centre for International and Tropical Health and Nutrition, and the principal author of this paper, Professor Lenore Manderson, has made important theoretical and practical contributions to TDR's field research and training activities. It is therefore seemly that Prof Manderson and her team inaugurate this new Resource Paper series, based on the significant achievements of Australia's international assistance programmes.

Carol Vlassoff
Manager, Gender & Tropical Diseases Task Force

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INTRODUCTION

Since the publication of Boserup's now classic work *Women's Role in Economic Development* (1970), which drew attention to the impact economic development on women, there has been a growing interest in gender, aid and development (Rogers 1980; Rathgeber 1990; Thomas and Skeat 1993a). This interest has led to the development of strategies aimed at increasing the gender sensitivity of national, multinational and non-governmental organization (NGO) bureaucracies concerned with aid and development. This includes increasing the number of women directly involved in development programmes of those agencies. It aims also to ensure that development programmes address issues which affect women, related to their multiple roles both in production and reproduction (Bandarage 1984; Pfanner 1986; Anderson 1990; Knapman 1990; Rathgeber 1990; Rhodes 1990; Corner 1992; Thomas and Skeat 1993b; Wigglesworth 1993).[1]

Recent research has drawn attention to the relationship of gender and health and highlighted the "significant disparities (that) exist between women and men" (Ojanuga and Gilbert 1992:613; see also Fitzpatrick and Manderson 1989; MacCormack 1992; Rathgeber and Vlassoff 1993; Vlassoff and Bonilla 1994). In addition to infectious disease, poor water supply, inadequate sanitation and the lack of other health infrastructure, a wide range of other social and cultural factors "negatively impinge upon (women's) physical well-being and accessibility to appropriate health services" (Ojanuga and Gilbert 1992:613; see also Puentes-Markides 1992). Women's health is influenced both by biology and by cultural institutions which define power relations within households and between men and women, determine household responsibilities and priorities, and influence women's access to knowledge and resources.

Further, while sex differences are most obvious with regard to reproductive health, gender is implicated across all diseases. Research on gender and tropical diseases, for example, has highlighted the particular disadvantages that women face with respect to risk factors of infection, the social costs of disease and access to care (Manderson, Jenkins and Tanner 1993; Wijeyaratne et al. 1994). These tropical diseases – leprosy, malaria, schistosomiasis, filariasis (including lymphatic filariasis and onchocerciasis), the trypanosomiases (Chagas disease and African trypanosomiasis) and leishmaniasis – are all diseases of poverty, and the geographic distribution of most of these diseases exacerbates the difficulties that people face when attempting to avoid infection or seek treatment. Many of the problems that women face with respect to these diseases, too, are similar to those they face for other diseases. But gender compounds this burden. Limited access to education for women suggests that women are less likely than men to have information about these diseases and

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[1]The literature on women and development is extensive. Among useful bibliographies, see Shah (1993) and White (1985).

their presentation. In addition, they are less familiar with medical services and may be reluctant to use them. They lack control of financial resources (often scarce) and therefore cannot or will not divert them for their own health (Raikes, Shoo and Brabin 1992). Their general low status, and their internalization of this, means that women give their health care low priority. The sequelae of untreated infection – particularly for diseases which cause gross disfigurement (filariasis, leprosy, onchodermatitis, leishmaniasis) – further compromise women's physical health and also carry social costs, including social rejection, isolation and/or divorce (Amazigo and Obikeze 1991; Amazigo 1994). Health problems with urinary or genital complications, such as urinary schistosomiasis with blood in urine, or filariasis where there is genital involvement, are rarely reported. There is also much that we do not know about the biology of these diseases, including intensity of infection and progression of disease with pregnancy (Brabin and Brabin 1992; Ulrich et al. 1993; Feldmeier and Krantz 1993; Feldmeier, Poggensee and Krantz 1993; Vlassoff 1994).

The links between gender, work, health and illness are particularly complex. Illness in women affects their work capability, including both household and other productive work, although perhaps not for all infections: the impact of asymptomatic infection on productivity is not quantified; and even in the case of symptomatic schistosomiasis, the evidence is equivocal (Parker 1992, 1993). In general, however, sickness limits women's ability to work. Conversely, the nature of women's work may cause ill health. The sexual division of labour and the "sexual division of responsibility" (Rathgeber 1990:499), together with local ecological, environmental, economic and cultural factors, influence exposure to infection and the risk of disease. While in some cases this means that men carry the burden of infection, for other diseases women are at greatest risk (Huang and Manderson 1992; cf. Tang et al. 1995). In the same way, reproduction may compromise women's health and conversely be compromised by women's poor health prior to pregnancy: that is, women's ability to conceive and carry to term is impaired by ill health, while women's lack of control over their reproduction may result in ill health, through lack of access to contraceptive technology and inability to space births.[2] As already noted, women's health is also affected by their access to health services; this may be limited by low education and inadequate information, inability to diagnose signs of infection and seek appropriate treatment, lack of resources to cover transport, service and treatment costs, restrictions on mobility and availability of time (Leslie 1992a), the inappropriateness of services and poor quality of care (Mensch 1993). Another major reason women delay in seeking medical care is that they endure considerable discomfort and pain before they acknowledge they are unwell, due to arduous workload expectations in the field, at home and as a result of childrearing: "women tend to suffer in silence and do not come for treatment because the threshold of illness recognised by the society on the illness–health continuum is so high for women that they endure so much in order not to disrupt household organization" (Okojie 1994:1237).

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[2]Indeed, as Gottschalk and Teymour (1993:111) note, "(women's) struggles for personal and reproductive freedom are integrally linked with their dependent economic status."

Yet precisely for this reason women have been subject to government attention in the context of health programmes: not for the sake of their own health, but because of their roles as carers and nurturers within the household, in which context they are responsible for their family's health (Leslie 1992b; Richters 1992; Allen 1993; Koblinsky, Timyan and Gay 1993; Rathgeber and Vlassoff 1993). As Pinotti argues, in the past the majority of the women's health programmes such as maternal and child health (MCH) and family planning were targeted predominantly at demographic issues and the health of the child, rather than women's health as a whole (Pinotti 1994; see also Richters 1992; Okojie 1994). Hence the links between women and health encompass women's roles in the production of food and goods, and as wage earners, and in biological, domestic and social reproduction through childbearing and childrearing, through their care of the sick and, more generally, the maintenance of the domestic environment, the preparation and provision of food, and the imparting of information to others relating to the prevention and treatment of illness and the maintenance of good health (WHO 1985; Raikes 1992:19).

A number of factors affect women and the health of their children, including maternal education level, women's status (operationalized to indicate power and control over resources), differences in the health status and treatment of boy and girl children, women's personal income, women's access to health services and general living conditions (Stinson et al. 1986; Chatterjee 1990; Vlassoff 1990; Young 1981). Hence Raikes (1989:456) argues that "the social and economic conditions of women's lives affect their overall health, their reproductive lives and the lives of their children in a complex process of interaction, and for this reason ... it is necessary to look in more detail at the precise interaction of the processes of production and social reproduction and their impact on women's lives and their health." Women's health cannot be viewed solely in terms of reproductive health; and Edstrom (1992:38) argues that the definition of women's health needs to be expanded to encompass their total health needs, resulting in a holistic approach which embodies the broad spectrum of socioeconomic and cultural aspects of health. "It is high time to begin to portray and measure women's health in a way which actually considers women's health for its own sake, rather than for some other purpose, such as population control or its opposite" (ibid.:48).

In addition to the recent attention to issues affecting women, gender and development, there has been considerable interest in community participation, self-determination and empowerment in the context of primary health care (PHC). The 1978 Alma Ata Declaration (WHO 1978) led to growing emphasis on community participation and PHC. This, MacCormack (1992:831) argues, "must surely have an impact on the health of their families and their communities ... when women's health skills are genuinely enhanced, women are often able to achieve a higher social status." MacCormack maintains that this, in turn, results in social empowerment and increased social status for women.

ENGENDERING HEALTH AND DEVELOPMENT PROJECTS

The emphasis on community is one that has extended beyond health and takes into account a growing concern that development projects reflect basic needs, local requirements and the capacity to ensure the successful implementation and sustainability of projects (Raikes 1992:24). As Hunt (1986) and Rugendyke (1991) describe it, the focus for development has been increasingly on six alternative approaches: appropriate technology, generation of employment, integrated rural development, women and development, community participation and basic human needs. In reality, these approaches overlap or are inclusive, and funding agency preference has increasingly been for projects which incorporate all approaches, including the involvement of women from the outset (Rugendyke 1991; Zivetz et al. 1991; Welbourn 1992). This was the case in the South Pacific women's reproductive health videos project, discussed in greater detail below, where women "owned" the project from its inception to its successful completion. In addition, community participation in health largely falls to women in their role as first-line health providers as well as consumers. NGOs have been particularly active in initiating projects in response to this emphasis, as they are well suited, ideologically and organizationally, to working at a community level and dealing directly with programme recipients.

Over the past decade, considerable expertise has accumulated with respect to both community participation and women and development. Details of NGO projects and analyses of their successes and failures are not widely available, however. There is little in the public record that describes or evaluates strategies or interventions that have improved women's access to and use of health services in developing countries (Vogel 1993), since much of the documentation is unpublished or restricted, and accountability is primarily to funding sources. Details of development projects, the results of community surveys and other applied research conducted by NGOs rarely find their way into the scholarly literature, yet they provide valuable information and insights into health and gender issues (see Franklin 1993 on HIV/AIDS in Viet Nam).

This paper is concerned with women's health projects, particularly those initiated and run by NGOs, which have worked in various country settings in collaboration with local community-based organizations to identify women's health priorities and develop, implement and evaluate health projects. This paper draws on information obtained from interviews with individuals working with Australian NGOs, and from a review of unpublished reports and in-house documentation provided by these organizations. Since the NGOs are Australian, there may be some unique features of the projects, but we believe that the general approaches adopted, and the lessons learned, are more widely applicable. We describe several projects in which Australian NGOs have been the instigating, implementing or managing agencies. We focus on strategies and processes that appear to have succeeded – and some that have been problematic – in increasing women's access to and use of health services in developing countries. In particular, we wish to draw attention to

commonalities of approach in empowering women to determine their own health needs and to "own" and control development projects. We include a number of case studies in order to illustrate these issues, although as we note throughout the paper, there is no single formula for successful women and development, or women's health, projects. Health interventions must necessarily be developed in the light of local social, political, cultural and economic circumstances.

The data presented below were collected in a research project undertaken during 1993–1994, when we collected information on 16 projects through interviews with individuals and a review of unpublished reports and in-house documentation from a variety of sources.[3] The projects were based in Africa, China, Southeast Asia, the Pacific and South America, and implemented by local or community-based organizations with Australian NGO involvement. The projects reviewed were diverse in location and in purpose, despite their common primary emphasis on women's health, and they included income-generating activities; functional literacy training; integrated PHC and MCH; women's crisis centres; community health and development; development of reproductive health videos; traditional birth attendant (TBA) training; community health education and training; and family planning. The projects were fully funded by donor and local NGOs, integrated and expanded within existing health infrastructures, or they were established and sustained on a cost-recovery basis by local NGOs or individuals. Facilities, services and/or equipment were made available to identified target groups in all projects reviewed, despite logistic, geographic or cultural constraints. Each project was tailored to fit with local needs and perceptions, local resources and infrastructure, and hence, as stressed by many NGO representatives, what works in one country or setting may not be transferable to another country or a different cultural context (see Aguwa 1983:60); the challenge remains to identify common issues and approaches that can be utilized across regions and cultures. Seven projects are described in detail below and exemplify the value of participatory approaches involving women from assessment, to planning, to implementation of each project.

As we have already explained, in this review we emphasize projects concerned with women's health. Yet virtually all development projects impact, in some way, on women's lives, and hence also on their health, even if the association between women, health and development is not straightforward. In Australia, "the task of translating the official women-in-development policy into practice was to prove slow and difficult" (Pfanner 1986:309). However, NGOs have increasingly addressed issues related to women and their health primarily through community participation projects developed on the premise that active

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[3]Additional resource materials and other information were obtained from organizations such as the Asian and Pacific Development Centre (APDC) in Kuala Lumpur, the Population and Resources Division of the World Bank, the United Nations Development Fund for Women (UNIFEM), the Australian Development Studies Network (ADSN) and the National Centre for Development Studies (NCDS) of The Australian National University (ANU), the Australian Council for Overseas Aid (ACFOA), and individual development consultants.

participation is a prerequisite for programme success. Despite the equivocal findings of some studies of the long-term value of community participation (Bossert 1990; Kennedy 1991), community participation is important for local and national commitment. In addition, there is a wider commitment from both funding agencies and NGOs to community-based projects and to what is widely referred to as a "bottom-up" approach as being cost-effective, as having a "catalytic role" in encouraging sustainable development (Rugendyke 1991:1), and, in the context of women's health, reflecting the spirit of the Alma Ata Declaration. Insofar as general living conditions and the availability of resources and services affect women and their children as well as men, any development issue is by definition a woman's issue, and any improvements in living conditions have the potential to improve women's health. Yet, as Thomas points out (1986:1), little consideration was given until recently to the influence and long-term impact on indigenous social, political and economic systems of development projects, development programmes have been concerned largely with "changing what men do", and "little consideration has been given to either involving women in the development process or to the impact of male-dominated development programmes on the lives of women." There is an "increasingly urgent need for project planners to consider both male and female roles as well as long-term evaluation" (ibid.).

ASSESSMENT OF WOMEN'S NEEDS

In a relatively recent article, Carol MacCormack (1992) spells out the most appropriate data collection methods for planning as well as monitoring and evaluation. Depending on the kind of data required, MacCormack primarily suggests interviews, structured questionnaires and the cautious use of available statistics. For the more complicated task of determining women's common illnesses and relating these to the sexual division of labour, she recommends a mix of methods that draw more heavily on participant observation (see also Brems and Griffiths 1993:266–269). MacCormack does not include focus groups in her checklist, but these have become a common tool to assess local needs and programmes, either alone or in the context of rapid assessment procedures or rapid rural appraisal (see Scrimshaw and Hurtado 1987; Khan and Manderson 1992; Manderson and Aaby 1992a, 1992b; Welbourn 1992; Franklin 1993). In other cases, simple surveys have been used to provide a brief sketch of local priority and need (Sloss and Munier 1991).

Most published papers concerned with women's health needs, as well as the unpublished reports of the Australian NGO projects, reflect a commitment to "participatory planning". This, Puentes-Markides (1992:625) argues, enables the negotiation of community demands and needs, facilitates decision making and helps interactions among individuals to convey concepts and analyse available skills. In a number of published papers, the operative verb used to describe the process of identifying women's needs is "listening" – hence Welbourn writes of "listening to needs" (1992) and Brems and Griffiths (1993) of "learning to listen". This is a political as well as a technical stance, inverting the conventional power relationships of development agents and professionals on the one hand and recipient

communities on the other. In some Pacific nations, NGOs are seen to be limited in identifying projects because of their historic welfare focus and the institutionalized background of their staff. This has curbed communication (hearing what women require) and negotiation at all levels of projects. Women's NGO projects in Western Samoa are seen to have a narrow social welfare focus and are therefore viewed both by the government and NGOs as "marginal" (Fairbairn-Dunlop 1990:123–125). In a detailed account of the activities of a Western Samoan Women's health committee to improve village sanitation, MCH, and nutrition, Thomas (1986:16) concludes that successful intervention "is complex and involves women's and men's reaction to interventions as well as the specific way in which the receiving society is organised and the values and assumptions which underlay this organisation." Any development project at village level "introduces new patterns of organisation and behaviour"; if changes are to be accepted by village communities, they need to be adapted to fit in with existing values and social organization (ibid.). This may, in turn, reduce the effectiveness of a project, whilst nonetheless ensuring its continuity – hence the title of Thomas's paper "Women and Development – A Two-Edged Sword", by which she highlights the contradictions that often arise between indigenous values and patterns of behaviour on the one hand, and project viability on the other.

The public/private divide of women and the philosophy of welfare ideologies needs to be challenged in order for women to present their demands and needs from projects, which will ultimately lead to empowerment. In examining an NGO project in a small Indian village, Price (1992) found that women were empowered through the formation of women's groups. Women were offered support to enable them to meet together, which led to awareness raising, then to the mobilization and organization of women. The "politics of need interpretation", where women move from the private sphere to actively voicing their corporate needs, can lead to their greater empowerment: "pre-established modes of service-delivery for development limit the opportunities offered to oppressed groups, such as women, to express their own needs" (ibid.:56). Welbourn (1992:12) makes the point that communities are not necessarily homogenous units, but highly structured diverse groups, and that NGOs and other donor agencies "have a set of blueprint agenda of health care, education or water programmes" which may not be in accordance with individual communities' perceived and expressed needs. This can clearly be seen in relation to the needs of Pacific women, where Kingstone (1990:103) explains that women generally are not consulted by NGOs about development plans, either nationally or regionally, because the agendas and objectives of donor agencies do not always correspond with the priorities of Pacific women. Kingstone (1990:107–108) also argues that to be in control of changes that will affect their lives and those of their families and communities, women need to be consulted and involved in development planning. In addition, Kingstone highlights the lack of concordance between donor and recipient expectations at the outset of programmes, and the resulting outcomes that often cultivate further dependency on programmes.

Wong and Chen (1991:43), in their description of a health development project in a remote area of Sarawak, Malaysia, document the processes of mobilizing village women "to plan, implement and evaluate a self-help kindergarten and children's feeding programme". Despite little or no experience in participatory planning by local women, training was conducted in small interactive groups, using games, dialogues and focus groups. A local survey on health needs in their community was subsequently carried out by these village women, who then devised strategies to deal with identified health problems. As summarized by Wong and Chen (1991:45): "women in rural communities possess particular skills and capabilities and may have clearer ideas than external agents about the feasibility and viability of projects"; they emphasize, too, the importance of communities being involved in planning processes if they are to implement projects, and the benefits of decentralizing management of projects to the local committee level, to sustain local commitment and allow for flexibility and adaptability in running the project to fit with the changing needs of the community.

An appreciation of the interrelationship of various social, economic and environmental issues affecting women's health is evident when communities are given the responsibility of identifying their own needs and setting their own goals and targets. Most projects we reviewed used participatory discussions at the community level to determine women's needs and priorities. These had the following characteristics: they were developed over time and used a "bottom-up" approach, enabling women to express their perceived needs; local NGOs as well as individuals involved were already part of the community, as in the case of members of women's unions or councils; the Australian (implementing) NGO worked closely with the local NGOs and existing institutions such as hospitals, government ministries, training colleges and universities; baseline assessment surveys were conducted to determine problems and needs, and these functioned as a database against which outcomes could be compared. Focus group meetings were conducted in some projects to identify and prioritize women's needs, or to verify information attained during needs assessment through key informant interviewing, limited observations and/or analyses of available data. For example, focus groups in Zambia allowed NGO fieldworkers to identify contradictions in fact, perception and interpretation, in this case where women's and men's explanations of transmission of sexually transmitted diseases (STDs) and condom use were quite divergent (Philpott, Milimo and Mufwaya 1993). Projects also used secondary data and government sources to collect cultural and social information, to assess shortfalls in health services for women and children and to identify priority areas. Discussions often then occurred at higher levels (governmental and institutional), and in most cases, funding was applied for and procured by the Australian NGO, then implemented by either the local or Australian NGO. This order of procedure was typical and emphasizes the community-based approach that is characteristic of many Australian and other development projects (Zivetz et al. 1991:34).

Gender issues were acknowledged and taken into account in nearly all projects which were reviewed. This was not surprising, since they were included for review precisely because of their attention to women's and children's health needs and well-being.[4] What this meant practically varied in terms of specific projects and illustrates the ways in which women's health and gender inequities may be influenced by economic, political and infrastructural issues. Resolutions of such issues were diverse: facilitation of women's control over resources and their participation in community decision making; assistance to women in crisis, and the design and delivery of services in-country; administration and ownership of projects by women, who in one project were able to determine content and direction, which included improvement in literacy to enhance women's access to knowledge, the development of income-generating activities and the training of outreach workers.

In this paper, we use "training" to include outreach work, skills development, dissemination of information and vocational learning. Most projects incorporated some training components, including community education and awareness raising. Some also implemented "train-the-trainer" programmes and/or provided training for TBAs, village or community health volunteers, or government health workers. In relation to training of urban TBAs, Stephens (1992:816) noted that the "literature indicates that negative attitudes of allopathic health workers towards their traditional counterparts prevail and these can have detrimental effects on training" and that "further research is needed to describe systematically the advantages and disadvantages of collaboration with allopathic services."

The multiplier effect of training some women to train others is intended to enhance the impact of projects and increase the likelihood of their success and sustainability. Bossert (1990) asserts that a strong training component in projects, which includes in-country professional and paraprofessional training for health workers is a necessary component for the sustainability of projects. There is cultural and social value in training local women who are able to pass on their skills and knowledge to other women from the same and neighbouring communities. This approach not only helps to establish networks of skilled women but provides them with a means to support each other and to increase or consolidate their spheres of influence. This was exemplified in a poverty alleviation project in China with a train-the-trainer component, wherein each woman who was trained in poultry and pig husbandry undertook, in turn, to train another 10 women. The "ripple effect" of this project has obvious economic implications, maximizing aid investment. Richters (1992) argues that skills training and education should be a priority in health programmes because of the indisputable relationship between increased maternal education and declining infant, child and maternal mortality rates.

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[4]AIDAB (the Australian International Development Assistance Bureau, known since mid-1995 as AusAID), the Australian government funding agency, has a strong WID (women in development) programme, including, in the area of health, WATCH (Women and Their Children's Health).

The Women's Health Education (WHE) programme in Bangladesh, described by Sloss and Munier (1991), also illustrates the advantages of training local women as health educators, who then instruct classes of local women. This WHE programme targeted poor women in rural areas, and achieved its objectives because participatory approaches to learning were utilized and educational materials were available and culturally appropriate (Sloss and Munier 1991; Welbourn 1992). The same approach also proved successful in two projects we reviewed: the T'boli tribal women's project in the Philippines, and a peer education project with commercial sex workers (CSWs) in Songhkla, Thailand. In both these projects, women from targeted communities were taught skills and knowledge to impart to their peers. In the project for T'boli women, a baseline survey was carried out first, providing newly trained T'boli health educators with information against which they could compare the desired outcomes of the project. In the project in Thailand, CSWs were surveyed after the implementation of the project for their knowledge, attitudes and practices. The results of the survey clearly indicated that the educational objectives of the project had been attained.

Many of the projects included provision of services and upgrading or construction of health facilities. Where access to services was difficult because of time and distance to be travelled, facilities were located in the communities or within easy reach of them. In nearly all projects, there was recognition of sociocultural, religious and gender factors affecting whether or not women would seek health care (Timyan et al. 1993), and these were taken into account by implementing NGOs.

As already noted, women's work within and outside the home, and in pregnancy and lactation, both reflects women's status and has a direct impact on their health. Even simple engineering projects may positively impact on women's lives, although not always in the direction intended. The provision of piped water, for example, can dramatically reduce time and labour needed to fetch and carry water. This is illustrated in a project in Zambia (Philpott, Milimo and Mufwaya 1993:5), where women had much heavier workloads than men and were responsible for household work, the care of children, the sick and disabled, and all household duties including fetching water and firewood. Ready availability to water gave them greater time for other domestic activities, although it did not increase either rest or leisure time.

Women's status is further affected by the reluctance of programmes to address issues of sexuality, thus curbing the effectiveness of outcomes on women's health as noted by Gordon and Kanstrup (1992). Integrating sexuality within health programmes "would highlight the ways in which existing power relations between men and women, generations and people with different sexual orientations have severely detrimental effects upon the health of the whole community" (ibid.:37). For many, gender inequalities originate in childhood – boys receive higher standards of medical care and visit health facilities more frequently than girls, resulting in excess childhood female mortality. "Gender inequalities in the modern health care system are manifested largely in the lack of access to health care by

women and girls, including lack of access to health information, to health facilities, etc." (Okojie 1994:1242). Furthermore, women in many poor countries cannot decide individually to make use of health services or to seek care, since the decision is made by their husbands or other family members. "The subordinate status of women in many Third World societies limits their autonomy in decision-making, it limits their access to transportation, and leads to discrimination in health care utilisation. It is women's untimely use or non-use of health services that results in high maternal mortality rates and to suffering by millions of various gynaecological problems" (ibid.:1244).

Availability of child care influences women's participation in a variety of activities, including those developed through aid projects to increase income, which in turn might impact on women or their children's health. For example, in a project in Indonesia,[5] one of the factors precluding women from attending the literacy programme was a lack of child care for the time required to attend training sessions. Once this was recognized and rectified to some extent, and women were satisfied with the safe care of their children, attrition rates dropped and attendance rates increased. However, training, income-generating activities, education and the provision of health services do not necessarily ensure a reduction in women's workload or responsibilities, or their promotion to positions of influence and/or authority. Social change such as this is not so easily engineered.

In the projects described below, evaluation was relatively pragmatic: a successful outcome would include changes in rates of utilization of health services. Subtle changes in women's health-seeking behaviour, health priorities and well-being tend to be assumed, or documented anecdotally only. However, a few of the projects aimed to improve women's health indirectly through addressing associated economic and educational problems, as defined by the women. These reputedly fared well. Empowerment is a catchword in internal evaluations, but it implies a real shift in women's position to one of increasing power within the context of their prior status in their communities. Examples of this are seen when women achieve economic independence and become autonomous through income-generating projects and skills training, whether or not these are related to health.

CASE STUDIES OF WOMEN'S HEALTH AND DEVELOPMENT PROJECTS

In this section, we summarize a number of projects which illustrate participatory approaches in their conceptualization and development, and which ultimately raised the status of the women involved and empowered them to instigate further projects and retain ownership over the initial projects.

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[5]Australian NGO, Freedom from illiteracy project and small project initiated by women, 1991–1995. (Because of political sensitivities of the NGO and the Indonesian Government associated with the Dili massacre, the NGO's name was to be withheld in publications.)

China: Animal husbandry and the improvement of health care

Rural women in China – and most other poor countries – often work hard without any financial remuneration and lack the skills to generate income. In this project in Guanxi Province, China,[6] women gained status by attending pig husbandry courses, an activity not normally undertaken by village women. Poultry husbandry courses were also implemented. The husbandry project, which women felt would raise their income-generating capabilities, aimed to fulfil needs which they identified themselves. Women's horizons widened because they travelled beyond their local villages to the county capital to learn pig husbandry skills and to meet other women whom they would probably not have met otherwise. Some 5000 women were trained in groups of 50; women got to know each other through sharing accommodations and attending the courses together. The acquisition of new skills was their first step to empowerment. Seed money for the project was used to buy piglets, which were then husbanded to produce piglets to sell, and with new knowledge and a small loan, the women were able to increase their overall income. The All China Women's Federation, a government body, visited the projects in Du An County after hearing of their success from the Ministry of Foreign Affairs and Economic Co-operation, became closely involved and, in turn, also gained kudos.

After the animal husbandry training programme, village women decided that the provision of basic health services was a priority in the county, which included poor minority populations and was underserviced. The decision to improve local health services resulted in a programme to train some 200 women as "barefoot doctors". Thus, this scheme too was conceived by women in response to a recognized need, and they requested funding assistance to instigate the barefoot doctors' programme to serve about 80 villages lacking basic medical facilities. On behalf of the village women who had attended the animal husbandry training programmes, the All China Women's Federation approached the Australian NGO, and they jointly developed and implemented the Barefoot Doctors' Training Programme (1993). The Australian NGO, with the All China Women's Federation, is now involved in developing a project for up to 300 women, to be implemented at county level by the Women's Union. Village women will be offered a training course in tailoring and basic business management, at the end of which they will be eligible for loans of $100 each to buy sewing machines to establish tailoring businesses. Half of the loan will be paid back into a revolving credit fund for other women. The initial projects have therefore had a significant multiplier effect (cf. Chu 1994).

The women involved in this animal husbandry project enjoyed enhanced status by developing their skills and generating income. Unlike many other women who leave their

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[6]CARE Australia, Monitoring a poverty alleviation project in Guanxi Province, China: small projects for women of poultry and pig husbandry income-generating schemes and a barefoot doctors' training programme, 1993–1994.

home areas if they become skilled, these women have remained within their communities and continue to contribute as active members. However, one of the unknown outcomes of the projects in China is that neither the implementing agency nor the All China Women's Federation know if the poorest of the poor have been reached or are benefiting in any way from these schemes. Even with the use of local interpreters at the village level, this could not be ascertained.

Indonesia: Literacy and hygiene

In Indonesia, a literacy training project arose from the needs of illiterate members of a small traders' group that ran a savings and loan scheme. Over 70% of the group's members were illiterate, and this affected the functioning of the groups. Following internal discussions, the small traders' group contracted a Jakarta-based NGO to run a needs assessment and train-the-trainer programme in literacy for its salaried staff and volunteers. The programme had a high attrition rate, however, due to its highly didactic teaching methods. A new curriculum and alternative teaching method were developed, focusing on local issues and using the print media to illustrate local situations to prompt discussion. The new format was successful in attracting new members and retaining the interest of existing participants.

After three months, women identified access to clean water as the next crucial issue for their community, and as a consequence, with some assistance from a local NGO, the women organized their local community to dig the first of three wells. In this project, women's self-confidence was enhanced by functional literacy training; they then identified the need for and decided to have wells dug, thereby resolving issues related to work and labour (time taken to carry water), water quality and hygiene (improved access to potable water). Outcomes of the project included women's increased capacity to work effectively and increased personal status. This was reflected by the reported enhancement of women's position in the home, their improved understanding of legal documents, their ability to administer both household, savings and loan scheme budgets, and reduction of pressure on divorced or widowed women to remarry, in an area of high divorce rates. A number of husbands of women participating in the project were also attracted by its activities, and several subsequently joined the literacy classes.

Zambia: Primary health care

This five-year project aimed to improve the health status of people living in the wards of Lumanya and Masaba, in the Samfya District of Luapala Province, Zambia. The main objectives of the project were to (a) construct three health centres to increase effectiveness of health service delivery; (b) establish and implement a PHC strategy to enhance the health of women and children, including access to safe, potable water which was highlighted as a WID (women in development) component; and (c) facilitate the control of women over

resources and their participation in community decision making, aimed in turn at helping them to reduce their workload and improve their health.

Strategies used to achieve these objectives included providing infrastructure such as establishing water wells and grinding mills; training community health workers and traditional birth attendants; improving delivery of health interventions such as immunization, oral rehydration therapy and family planning, sanitation, HIV/AIDS education, nutrition and malaria prevention; and promoting income- generating activities. This project thus combined a number of approaches, as it emphasized both PHC and broader community and WID objectives. In the first three years (1991–1994), training was provided for 57 CHWs, 52 TBAs, 48 WID leaders and 63 headmen and chiefs (for PHC orientation). Mobile health teams and improved access to health centres meant a reduction in the time and workload for women in obtaining access to immunization, so the project had a positive impact on women and their children's health. The project achieved increased attendance rates by mothers at clinics, over 90% immunization coverage of children in some communities and 76% coverage for maternal tetanus toxoid immunization. But not all components of this project were equally successful. Uptake of family planning methods did not increase, despite most women being motivated and wanting to use contraceptives, owing to opposition from husbands. In a few cases this was verified, since many men believe that women should not stop producing children "until God stops them producing".

Distances to services such as grinding mills, health centres, water wells and stores have been greatly reduced for many households. At least 5 of 12 communities now travel less than 3 km to their nearest store, having previously travelled by foot and then by bus for up to 85 km to get supplies from the main centre. At least 6 communities now travel less than 2 km for water, and 3 communities have less than 3 km to their nearest health centre. But here, too, although physical access to health services has improved, some women are still disadvantaged and without access to health centres, water wells, stores and grinding mills. Some communities still have to travel more than 10 km to a grinding mill, and many must travel over 6 km to a health centre.

The project has a strong focus on women, and despite some resistance from men, women's groups have flourished since its inception. Yet there are few signs of real changes in women's workloads (one of the objectives of the project), and in some cases the workload had actually increased due to women's involvement in income-generating activities, indicating the need, perhaps, for "a more gender sensitive approach rather than a strict focus on WID", which would take account of the sexual division of labour and allocation of power in the development of projects (see e.g. Philpott, Milimo and Mufwaya 1993:25).

In this context, it is important to note the effect of this project on men as well. Men felt disempowered within their own community by not being able to have access to loans and other benefits from the project, and there was some resentment of the favoured status given

to women. Many felt that the business activities and agricultural support should have been theirs, and project implementation was impeded by men's resentment of woman-focused projects, including overt opposition, lack of assistance for women who started to learn traditional male tasks and efforts to subvert the process or divert assistance from the project back to men. Women were also under pressure to get personal loans to support men's activities.

Equipping, staffing and maintaining services provided by the health centres will strain limited resources of the Ministry of Health, and although the project was designed to assist the community to regard it as their own, the majority of people appear to view it as an NGO or government project, looking to these institutions to provide nearly all the input. Ownership of the project appears incomplete, as PHC is viewed as part of health service delivery; for the same reason, CHWs and TBAs have little community support. In addition, concerns of dependency (on services and staff involved with the project) by the community were expressed by the evaluation team. This had political overtones; the project review team noted that in community meetings, people had a "shopping list" approach and resented being asked to do things themselves that they had been told by governments and politicians would be done for them. They presented the evaluation team with a list requesting a bank, another road, glass windows for houses and health centres for villages. The evaluation team made it clear that material items for the health centres and houses were not being offered, and it was noted in the evaluation report that "old patterns of thought and behaviour change slowly" (Philpott, Milimo and Mufwaya 1993). Project staff in the area tended to perpetuate this lack of community involvement.

South Pacific: Reproductive health in Tonga, Fiji, Kiribati, Solomon Islands

A study of women's reproductive health in the South Pacific was undertaken in 1984–1985 for Family Planning Australia (FPA) by two Australian consultants. In 1987, FPA was funded from AusAID (then AIDAB: Australian International Development Assistance Bureau) to produce reproductive health videos that would meet needs identified by Pacific women. The project produced four reproductive health videos and a culturally acceptable lexicon.[7]

Initial contact with village women came from local staff. The researchers tapped into the extensive network of women's groups throughout villages and towns of the region, and spoke to rural and urban women in Tonga, Fiji, Kiribati and the Solomon Islands – a cross-section of Polynesian, Melanesian and Micronesian people. Pacific women's health needs and wants were established through unstructured interviews and informal discussions. Women responding decided that videos would be the most effective means to disseminate the information they wanted to present. The content of the videos was decided on by a

[7]Margaret Winn and Family Planning Australia, South Pacific women's reproductive health videos project, 1984–1989 (completed in 1993), South Pacific: Tonga, Fiji, Kiribati, Solomon Islands.

similar process, and also in consultation with heads of women's committees, the councils of women and talking to ordinary women. The four reproductive health videos produced by FPA documented women's feelings on reproductive health; provided practical information on AIDS and the reproductive system; and presented a story about STDs and community response. Originally produced in English in response to women's requests, these videos are now also available in PNG Pidgin (the lingua franca of New Guinea), Samoan, Tongan, Fiji and Hindi languages. Although people in power had expressed concerns that issues raised in the videos were too sensitive to be discussed, production of the videos over a long period of time showed that Pacific people were far more open to the idea of sexuality education than their spokespersons (usually men) would give them credit for (Winn, pers. comm.). Another outcome was repeated requests from Pacific men, after seeing the videos, to also speak out frankly on family planning issues, and have a video for males. Men and women requested more videos on sexuality and contraceptive methods targeted at men. Distribution and use of the videos is widespread through independent NGO FPAs in the Pacific.

From its inception, this project was administered by women, with women making all decisions and conducting all the work, hence ensuring their ownership and responsibility for the project, the original researchers acting only as facilitators and advisers. Pacific women were included in all phases of the project from research, to production, to distribution: it was a project "for women, by women, according to women's priorities" (Winn 1990:4). The project took into account cultural and religious sensitivities of those involved and was developed slowly over time; the researchers and facilitators were acceptable to the women in the communities they visited, and were prepared to listen for as long as it took for women to express their interests and needs in reproductive health issues. Using community decision-making processes was in keeping with South Pacific consensus tradition. The development and use of videos as a tool for information dissemination and social messages also came from Pacific women, and in all the working groups, the facilitators tried to ensure that members of all groups (large or small) had an equal voice. The project was flexible in time frame and content, and was adapted to the expressed needs of the women's groups. An evaluation in 1989 analysed the process of video production and the impact of the videos in terms of distribution, acceptability, appropriateness and effectiveness, and highlighted the content of the videos and their ability to generate public discussion about subjects previously avoided. The target audience determined the content of the project, as opposed to merely being consulted about it, and also determined the choice of language, communication medium and style of presentation.

Thailand: HIV/AIDS education

This project[8] was community based, and activities focused on commercial sex workers and fishermen, many of whom were also intravenous drug users (IVDUs). The overall aim of the project was to assist the Ministry of Public Health in Songhkla, Thailand, in the prevention and control of AIDS. Specific objectives outlined in the project design document were (a) to provide timely and effective information on the spread of HIV and AIDS in Songhkla Province; (b) to prevent and control the spread of AIDS among CSWs in Muang District, Songhkla; (c) to contact and follow up 750 CSWs in Muang District annually and provide counselling and ongoing support for 50% of those identified as HIV positive; (d) to prevent and control the spread of AIDS amongst the IVDU fishermen in Muang District, Songhkla; and (e) to provide initial and ongoing education on AIDS prevention and control to key ministerial staff in Songhkla (World Vision Foundation of Thailand 1993:4). Activities related to the objectives included recruiting and training peer educators for CSWs, and their involvement in developing HIV/AIDS educational materials (posters, pamphlets and audiotapes).

The manager of the programme was also the director of the VD clinic, which had a counselling and HIV testing centre situated in the same building. Services for CSWs have apparently improved since the project started. By law, sex workers must have weekly STD check-ups at the government VD clinic, and there is about a 70% attendance rate of brothel workers, who therefore come into contact with project staff regularly. The anonymous counselling centre located in the VD clinic is staffed by a counsellor funded by the programme. Because of its proximity to the STD clinic, many sex workers also come to the centre for non-HIV-related counselling. Anonymity of clients is assured, as records do not contain information that can identify clients.

The project worked in close collaboration with the Provincial AIDS committee, Songhkla Hospital, Narcotics Control Board, Prince of Songhkla University and Songhkla Vocational College, and collaborated with Hotline, a local NGO offering counselling services, and with other voluntary health workers. Emphasis was placed on peer education, with trained voluntary workers working as outreach workers and going to the "mamasan" of various brothels to distribute IEC (information, education, communication) materials. Training was also provided for Ministry of Public Health staff in HIV testing techniques, information and education training for prevention of HIV transmission for 47 health workers at the sub-district health centres, and counselling training for 13 ministry staff. Project staff met with peer educators weekly at the workplace for short discussions, and monthly for longer discussions when peer educators brought in activity sheets, discussed problems and issues of the past month, and were provided with educational materials and condoms by the project staff. A

[8]World Vision Australia (WVA), Songhkla AIDS prevention and control project, Thailand, 1991–1994.

common complaint reported by peer educators was that condoms were not good quality, were uncomfortable during sex and often broke. This problem needed addressing urgently to maintain credibility of the education programme, as condom usage had increased.

A preliminary assessment was made to determine community profiles and numbers of target populations. KAP (knowledge, attitudes and practices) surveys were then conducted prior to implementation of the project and again at the end of the first year of implementation. Methodologies used by the evaluation team included in-depth interviews with CSWs and focus group discussions with peer educators. Results of the KAP surveys among sex workers showed more than a 50% increase in knowledge, a 20% increase in attitude towards prevention and up to a 50% increase in "safe sexual practices" (presumed to be condom use) compared with the baseline data collected prior to implementation of the project.

This project worked because CSWs identified their own peer educators, who were paid for their services. The project did not try to be overambitious in what could be achieved and set realistic targets. Results showed that there was an increased level of awareness and knowledge about HIV/AIDS. Sex workers assumed responsibility for the continuation of the peer education programme and dissemination of information, indicating their commitment to the project's stated objectives, sustaining and improving the project, and consolidating work that had been successfully implemented and evaluated.

Lao PDR: Primary health care and maternal and child health

The overall objective of a PHC/MCH project in Lao PDR[9] was to improve the health status and well-being of the population of Sayabouri Province, with particular emphasis on rural village communities and specifically women and their children. The project included as fundamental components training, infrastructure, village outreach, project management and technical support. Aims of the project were (a) to strengthen the skills of over 300 health personnel by training, and to train trainers in innovative, participatory adult learning techniques and principles; (b) to upgrade/reconstruct existing health facilities to be able to conduct appropriate PHC and strengthen referral services in the project province; (c) to increase villagers' access to basic preventive and curative services through PHC/MCH outreach activities, and enhance their capacity to maintain responsibility for their own health; and (d) to effectively manage the project, including monitoring and evaluation.

The NGO, Save the Children Fund Australia (SCFA), ensured that implementation conformed with policies of its partners, the Lao Women's Union (LWU) and the Ministry of Health. SCFA's participatory self-help approach, in partnership with local institutions and

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[9]Save The Children Fund Australia (SCFA), Integrated primary health care and maternal child health project, Sayabouri Province, Lao PDR, 1991–1994.

communities, sought to ensure that gender issues, environmental factors, social equity concerns and overall sustainability of the project were addressed sensitively and effectively.

This integrated PHC/MCH project aimed to train over 300 health personnel. By late 1993, it had conducted training of trainers courses, and courses on health information systems and health services management, as well as special courses such as control of diarrhoeal disease/acute respiratory infection (17 participants), malaria (17 participants), EPI (Expanded Programme on Immunization), HIV/AIDS (500 participants), and MCH (26 participants). The project also includes English-language training. Courses for village health volunteers (37 people, 30% women) and TBAs (136, 50% women) have also been provided. The training of district health staff as trainers to conduct their own independent training sessions has also been completed.

Gender issues were considered in the selection of trainers and training, selection of topics for training, designing curricula and planning village outreach activities. An estimated 80% of trainees now apply their skills, and in support of their work, the implementing NGO negotiated free government transport to the main referral centre for emergency cases. Training of village health workers and TBAs, and the construction of a new dispensary, have stimulated community interest and was, in 1993, expected to "impact on the community's internal organization and self-identity" (Draper 1993:11). The LWU has undertaken to replenish TBA kits as required, and villagers are contributing to the costs of providing village health volunteers with medical kits. The LWU has benefited to some extent through its involvement at all levels in project co-ordination.

Management systems are efficient and effective in Vientiane, and communications between the capital and Sayabouri have proved adequate, staff have been willing to participate, local contributions forthcoming and villagers willing to participate. The building of a new MCH centre at the district hospital, and a new village dispensary in the project area, increased women's access to services. There is a close working relationship between provincial health staff and the LWU local representative, and village health workers have increased MCH and immunization coverage. Outreach activities in these two areas has commenced in 10 villages of the project district. Skills of health personnel have improved and their motivation has increased; and institutional capacities (especially in training of MCH, health systems management and new buildings) have been strengthened.

No detailed health status data was available at the outset of project implementation, and changes in health status directly attributable to the project may not be evident in the short-term. There is increased utilization of health services however, and it is likely that MCH has improved already as a result of interventions in the project area. Provincial health services estimate that MCH attendance has increased by 22%, women's use of antenatal services has increased substantially, and there has been a 50% increase in deliveries at the provincial hospital. A government report on EPI shows an increase of 40% in coverage in

one year for two districts in the project area, and no outbreaks of vaccine-preventable diseases.

The Australian NGO has been operating in the country and providing support since 1988, earning it the respect, support and acceptance of the government and targeted communities during the period prior to implementation of the current project. The project has been seen as a model by the Ministry of Health at central level, as the approach adopted by SCFA is felt to enhance future sustainability by encouraging a sense of local "ownership", which can be adapted to the needs of other, remote provinces in Lao PDR. The success of this project is evidenced by a recommendation of high-level consultations between Lao PDR and Australia in 1994 that the SCFA PHC and integrated village development projects in Sayabouri Province be extended. This PHC approach "emphasises preventive, co-ordinated, team delivery of health services" and is in accordance with the high priority given to integrated social development and health by the 1994 mission to Lao PDR (AIDAB 1995:viii). National health programs, by contrast, were noted to "favour curative and independent vertical programs" (ibid.).

Philippines: Income generation and health education

The overall aim of this project[10] was to improve the health of 30 000 tribal women in the area of the Santa Cruz Mission, South Catabato, Mindanao. Australian Freedom From Hunger Campaign (AFFHC)/Community Aid Abroad (CAA) is the managing agency, and the Santa Cruz Mission (SCM) is implementing the project. Objectives were (a) to establish a planning information base; (b) to set up a health education programme with a participatory community survey process; (c) to supply potable water for 15 communities to relieve women of the workload of carrying water and to improve community health; and (d) to institute effective project management, including integration of SCM activities such as agriculture, involvement of students in community development, provision of basic health equipment in health centres, and staffing (25 health educators and 5 supervisors).

Tribal T'boli women were targeted because of their limited access to economic services, their central role in food production and income generation, and their low health status and lack of access to services. A review of morbidity data of the area showed that the health of men and women was not statistically very different, but women had the added burden of obstetric and gynaecologic problems, combined with malaria, worm infestations, poor diet and poor obstetric history, urinary tract infections and higher rates of gastroenteritis than men. Women also complained about pains and fatigue, believed to have been from weaving with backstrap looms.

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[10]Australian Freedom From Hunger Campaign (AFFHC)/Community Aid Abroad (CAA), T'boli tribal women's health project South Catabato, Mindanao, Philippines, 1991–1994.

Twenty-five women were trained as health educators, and they carried out assessment surveys of the target area to determine problem areas and needs and establish baseline data against which outcomes could be compared. This included a plan to research aspects of traditional healing to integrate into the health education programme. CIPS (community information planning systems) methodology was used and introduced to the communities after an initial training seminar. All 25 community centres conducted surveys, with teams headed by health workers and assisted by centre staff and students, which identified as priority community needs improved nutrition, shelter, health and education; environmental, personal, cultural and political security; and control over resources. Subsequent to their training, provided by the SCM, these T'boli health educators conducted training sessions for over 80 mothers in 7 community centres. Women themselves insisted on the inclusion of literacy in some of the education classes run by the SCM. Regular assessments and evaluation of the community health profile were planned, and health education, disease control and family planning advice were provided. The cultural and social relevance of trained women from their own communities, who pass on their skills and knowledge to other women from the same and other communities, established not only networks of skilled women, but a means for these women to shift their position within society and increase or consolidate their spheres of influence. Another strategy was the formation of committees, including one on T'boli composition of songs and drama, for information sharing among women. Cultural awareness and sensitivity was noted as part of the NGO appraisal in the design document, to ensure appropriateness of the project in responding to tribal needs.

Conducting a community health survey prior to implementation of the health educator's training programme provided baseline data on the health profile of the communities, against which outcomes could later be measured. Data boards (graphed results) were set up in each community centre as indicators for nutritional status, toilets, MCH classes, immunization, births, deaths, antenatal care, gardens and income generation. These were monitored for participating groups, and were believed to give direction and focus for health activities for community members and health workers. Within the first year of the project, potable water was installed and available in 5 of the 25 centres of the project, income-generating activities were established in 15 centres, and 22 health centres were medically equipped. Maternal and infant nutritional status improved, and maternal and infant mortality rates from ARI (acute respiratory infections) and diarrhoea were reduced. In one community centre, 74 children originally had "combined second and third degree" malnutrition; by the 1993 review visit, only 1 "second degree" malnutrition was noted. Livelihood (income-generating) projects such as duck and pig raising, soap making and weaving were also put in place. Soap production by women has resulted in 15 of 25 centres now producing low-cost soap for personal and family use. Health education classes were integrated with other activities such as literacy classes, infrastructure and agriculture, although some attrition from women's education classes occurred due to the intrusion of other activities.

APPROACHES THAT INCREASE WOMEN'S ACCESS TO HEALTH SERVICES

Women's effective access to health care involves the interrelationship of many complex factors. This can only be assured if services are considered available, affordable, appropriate and acceptable by women (Stinson et al. 1986:7, 35–44; Timyan et al. 1993:217–234). Physical availability and accessibility of facilities and personnel, while important requirements, are therefore not the sole determinants of effective access to care, and accessibility needs to be widely interpreted to take account of hours during which services are provided; cost of services and drugs, transport and time; and acceptability of the service providers to those presenting for care. Cultural, social, economic and political factors therefore complicate the infrastructural and institutional issues involved in the provision and use of health services.

Access to information and ownership of knowledge and information are also key issues in women's access to health care. Leslie (1992a:5) states that one of the main reasons for the lack of success of health projects is failure to understand women's normal patterns of time use in the community and to accommodate for this in planning. Intrusion on women's time required for activities necessary for their livelihood caused high attrition rates from education classes in the T'boli women's health project in the Philippines. Furthermore, the quality of care of services and their cultural acceptability are significant factors determining whether women will "incur time costs". If women's privacy is not maintained in the areas of reproduction and family planning, women will resent the health service or avoid it. Hull (1992:1) has argued that this is particularly so for reproductive health, where decisions about women's health and well-being are frequently made by male health specialists (although this applies only to the 50% of women whose pregnancies and deliveries are monitored by health professionals in the first place): "Studies from a range of countries have found that a major barrier to use of formal childbirth services is the perception by women that clinics or hospitals will be unable to meet their needs for privacy, emotional support, and fulfilment of rituals to protect their own or their infant's health" (Leslie 1992a:5). In addition, research conducted thus far on various tropical diseases suggests that women's needs to be well informed about their health, symptoms of illness and treatment options apply for all diseases (Amazigo 1994; Anyangwe et al. 1994; Kaendi 1994; Mwenesi 1994).

CONFLICTS AND TENSIONS

Projects which were reportedly sustainable emphasized the extent to which women were able to determine their own needs at the outset, participate in efforts to obtain funding, decide on their terms of reference, implement and continue the projects themselves to achieve common objectives and provide their own motivation for projects to be improved, extended or continued.

When the concept of PHC was viewed by communities as part of health service delivery, however, CHWs and TBAs sometimes lacked support from their own communities, as they were seen to be the responsibility of the NGO project or government rather than the community. Further, it is not always the case that when donor support ceases, structures will exist to maintain projects. Many women's lives remain unchanged by the projects, or projects shift direction over time. This may not be so in women-focused projects linked to health, small business or agriculture, as noted in the review of a community health and development project in Zambia (Philpott, Milimo and Mufwaya 1993; see also Manderson, Valencia and Thomas 1992). Other social, cultural and political factors continue to limit women's full participation in project activities, limiting also women's access to services (Noor 1976; Stoler 1976; Chandler, Sullivan and Branson 1988; Philpott, Milimo and Mufwaya 1993). A common assumption that women's workloads would be decreased through project interventions is also in question, as some women's workloads increased through involvement in income-generating activities and changed patterns of work. For example, tap or well water accessible to households may reduce time spent carrying water, but by increasing accessibility of water, the household use of water for domestic purposes may increase. Hence, some interventions may have the unintended impact of failing to reduce women's workloads.

Involvement of women in income-generating activities such as agriculture and business, where women gain authority and control, may result in men feeling disempowered, excluded and resentful. In Zambia, a development needs assessment study reflected what communities thought they needed, and a woman-focused project had design elements reflecting women's needs alone, creating a negative situation where men, unable to access loans and other benefits from the project, resented their lack of access to the business activities and agricultural support. Since village government and administration typically continues to rest with men, their support is often essential to a project's viability. Disagreement and resentment by men caused difficulties in project activities, resulting at times in explicit opposition from men, lack of assistance to women when undertaking traditional male activities and efforts to subvert or divert assistance from the project back under male control.

Sustainability is understood to depend on both human and economic resources, hence the importance of trained personnel and local volunteers to continue work beyond the life of specific projects. Several projects identified the lack of PHC workers as a major factor contributing to women's poor health, and accordingly aimed to increase their number. As we have noted, broadly, the educational components of the projects were designed to increase the numbers and competence of PHC workers and their use by the community. The educational components divide into three categories: (1) delivering general literacy skills and/or health education to all members of the community; (2) developing peer education programmes aimed at training a cadre of semi-skilled workers to supplement the work of health professionals; and (3) increasing the number and calibre of PHC workers through

training. District health staff were also trained to educate them, then conduct their own independent training sessions.

The success of training and health education components has been evaluated by agencies in terms of shifts in knowledge and skills, with the assumption that this will have a community-wide effect. As noted, train-the-trainer schemes have been particularly successful and are reported to have significant impact on the broader community. In China, each woman trained in pig or poultry husbandry undertook to train another 10 women in her community, ensuring expansion and continuation of the programme. Peer education was also successful in Thailand, where owners of brothels selected voluntary peer educators to raise awareness among CSWs, and to distribute condoms and health education materials.

Community participation development projects need to be designed to include women, to take account of women's interests and to consider the way in which such projects will affect, and be affected by, issues of gender (Rathgeber 1990). Projects that recognize and enhance the role and status of women enable women to assume greater control over their lives. In China, both the income-generating and barefoot doctors' training projects succeeded in increasing women's confidence in their ability to train other women, implement their own projects and generate income. Conversely, without the involvement of women in the design and implementation of health projects, their sustainability and their impact on women's status cannot be assured. Women frequently give higher priority to income-generating activities, literacy and piped water than to activities directed to reduce the incidence of particular diseases. When women have been able to set their own priorities, once their most important needs are met, their interest in health-related projects follows. Achieving and sustaining community participation in health-related areas is difficult (Manderson 1992; Manderson, Valencia and Thomas 1992). However, the Australian NGO projects reviewed in this study were strongly committed to community participation, self-determination and empowerment. As noted in those projects described in detail above, at their outset participatory discussions enabled women to identify and clearly state their needs. This was important to involve women in the project(s), to gain their commitment and to maximize the chances of project sustainability (cf. Kennedy 1991:7, 28). Kennedy (1991) points out that all evaluations, internal and external, should focus on process as well as outcome, and as we have noted, the projects reviewed were strong in terms of community participation.

Project success, however, relates also to the ability of NGOs to set realistic and achievable objectives to maintain the motivation of participants and ensure sustainability. In the project in Thailand, for example, directed towards the empowerment of CSWs, realistic targets were set. The epidemiology of HIV in Asia emphasizes the importance of working with CSWs (AIDSTECH 1992; Lyttleton 1994). Knowledge about HIV/AIDS had increased among CSWs after the first year of project implementation, and their reported use of "safe sexual practices" for prevention of HIV infection had doubled. Although these outcomes cannot be

attributed directly or exclusively to the project, some participants had observed changes in their and others' behaviour since being involved with the project.

Relationships between NGO project staff and local communities have proven to be highly significant. In these projects, NGO staff were known to the local communities, and were either accepted by or were a part of those communities involved in the projects. However, dependency of communities on services and staff involved with NGO projects can have political implications where governments have provided, or have promised to provide, all required services. Communities with these expectations may resent being asked to do things for themselves (Philpott, Milimo and Mufwaya 1993). On the other hand, governments, too, may depend on NGO involvement for the provision of services as well as financial aid: in the case of the T'boli project, for example, and with respect to other health projects in the country, the Philippines Department of Health has become reliant on the NGOs to meet gaps in service delivery and access.

CONCLUSION

We began by commenting on the increasing awareness and understanding of the importance of gender in determining health outcomes, and the crucial role that women play in health care within families and the wider society (Rathgeber 1990). Within governments and NGOs, including in Australia, this has extended to women and development issues and health. This is reflected in research, planning, implementation, monitoring and evaluation of health, gender and development projects, influenced both by the expectations and requirements of funding bodies that such issues be addressed, and by the sensitivities of the agencies and their key staff (Australia 1993:64–65; Zivetz et al. 1991).

In addressing women's health needs, reports of women, development and health projects, like the published literature on these subjects, emphasizes the importance of training women as health workers, skilled community workers, formal health educators and peer group educators in ways that fit in with local cultural, social and economic factors, in order to meet the need for a greater number of health workers in a variety of fields. Their need for continued education and support, to allow for consolidation of ideas and increased skills (e.g. through revision courses), and the need for continued supervision and support, has not been addressed in these documents, however; the emphasis remains on the initiation rather than the sustainability of projects (Manderson, Valencia and Thomas 1992).

The projects discussed here highlight some of the strategies that have influenced women's access to and use of health services. As we have described, all projects had an impact on women's health, either directly as a result of planned strategies, or indirectly due to unanticipated outcomes – raised status and empowerment of women from literacy training, other educational processes, income-generating activities or the formation of local NGOs or women's groups. The projects emphasize the value of listening to and talking with women at

local and community levels, via participatory discussions and focus groups, about their perceived and real health care needs, and stress the importance of this as a procedure prior to planning objectives and implementing project strategies (Wong 1989; Bossert 1990; Kennedy 1991). This process can also be used to assess the impact and efficacy of projects and to determine future directions and sustainability. While accounts of projects give particular emphasis to grass-roots involvement, attention is also given to the importance of liaising, developing rapport and establishing a clear understanding of project objectives with government authorities and community leaders to ensure acceptance, approval and political support for projects involving women. The difficulties faced by one project (Philpott, Milimo and Mufwaya 1993), in terms of men's opposition, underline the importance of both recognizing the need for, and gaining, widespread community support and co-operation. In addition, the project accounts emphasize the need for flexibility within programmes, so that projects might be adapted and modified to meet the changing needs and circumstances of women, as well as the variety of problems that arise, inevitably, in settings where communications and infrastructure are limited. Flexibility within programmes (Kennedy 1991; Winn 1992), assessment of women's needs prior to implementation and thorough planning emerge as vital factors in determining successful outcomes and sustainability of programmes.

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